Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Kirsch a prisoner at HMP Long Lartin on 19 March 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr David Kirsch died on 19 March 2018 of blood loss in his cell at HMP Long Lartin after cutting his neck. He was 52 years old. I offer my condolences to Mr Kirsch's family and friends.

The investigation identified deficiencies in the management of Mr Kirsch's risk of suicide and self-harm after his attempts to kill himself on 20 and 21 January 2018. Although staff started suicide and self-harm prevention measures, they did not assess Mr Kirsch's level of risk adequately or properly identify or address his numerous risk factors at that time, nor did they do so in the week before his death when his risk was escalating.

Suicide and self-harm case reviews did not make effective use of caremaps to manage Mr Kirsch's risk. It is disappointing that the excellent work of his recovery worker was not reflected into the final review which over-relied on Mr Kirsch's presentation. It is also disappointing that the doctor who saw Mr Kirsch four days before his death did not communicate her concerns about him to other staff.

Staff also made disciplinary decisions without appropriate consideration for Mr Kirsch's welfare. The decision to move him to another wing five days before he killed himself, weakened the support networks he had built with the help of his mental health key worker and meant that staff on the new wing were not fully aware of his risks. As a result, they did not give sufficient consideration to the concerns raised by two prisoners a few hours before Mr Kirsch killed himself.

I am also concerned that staff do not fully understand local and national policy about entering a cell at night which could be critical in preserving the life of prisoners in danger.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2018**

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Summary

Events

1. On 23 May 2008, Mr David Kirsch was sentenced to life imprisonment for the murder of his partner. He was given a minimum tariff of 18 years and five months before he would be eligible for parole. Mr Kirsch spent time at three other prisons before he was transferred to HMP Long Lartin on 21 Nov 2013.

2. On 20 and 21 January 2018, Mr Kirsch attempted to kill himself, first by jumping off his bed to hit his neck on the sink, and then by running head first into a metal gate on the landing. This resulted in him being hospitalised until 5 February. On his return from hospital, staff managed Mr Kirsch under suicide and self-harm prevention procedures (known as ACCT) and he was placed on constant watch in the healthcare wing. Staff carried out regular ACCT case reviews thereafter and on 13 February moved him to A wing.

3. On 13 March, Mr Kirsch was involved in a fight with another prisoner. This was unprecedented for Mr Kirsch. The next day staff decided to move him to another wing. On 15 March, he had an adjudication hearing at which he pleaded guilty to fighting.

4. On 19 March, two prisoners from his previous wing who knew Mr Kirsch well were concerned about his low mood and raised their concerns with staff. A supervising officer spoke to Mr Kirsch but he did not consider Mr Kirsch was at risk of suicide or self-harm and took no further action.

5. At around 7.50pm, an officer discovered Mr Kirsch on his bed with blood on his arm and radioed an emergency code. Nurses attended but did not attempt CPR because they considered that Mr Kirsch had died. The post-mortem report recorded the cause of death as haemorrhage and an incised wound at the right side of his neck.

Findings

6. Mr Kirsch had a number of risk factors for suicide and self-harm including the nature of his offence and a history of anxiety and depression. He attempted to kill himself in January 2018 and his anxiety appears to have increased from that point.

7. Although staff started suicide and self-harm prevention procedures and carried out multidisciplinary case reviews, they did not complete or update the caremap with suitable actions to address his risk or to build on his protective factors.

8. There was a lack of effective communication between healthcare staff and prison staff about Mr Kirsch's mental health issues and medication.

9. Staff made disciplinary decisions without appropriate consideration for Mr Kirsch's welfare. The decision to move him to another wing five days before he killed himself, weakened the support networks he had built with the help of his mental health key worker and meant that staff on the new wing were not alert to his risks.

10. We found that staff did not appear to understand and failed to comply with national and local instructions on entering a cell.

11. Mr Kirsch submitted a number of complaints over a lengthy period at Long Lartin. We found that staff took his complaints seriously and tried to provide informed responses for him. The complaint processes were reportedly stressful for Mr Kirsch but there is no evidence that they had a bearing on his decision to kill himself.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that they:
  - identify risk factors and assess a prisoner's risk considering his history and not just his personal presentation;
  - complete and update caremaps at case reviews, setting out specific and meaningful actions, including involving the family where appropriate, identifying who is responsible for actions and reviewing progress at each review;
  - share information to provide collaborative care and treatment, in particular ensuring effective communication between healthcare and prison staff when there are concerns about a prisoner's mental health; and
  - take into account the potential impact of restrictive measures addressing violence reduction and disciplinary issues on the welfare of prisoners with a clear history of suicide and self-harm.

- The Governor should ensure that all prison staff are made aware of PSI 24/2011 and the prison's night instructions and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is a risk to life or immediate serious danger.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact him. A prisoner responded.

13. The investigator visited HMP Long Lartin on 4 April 2018. He obtained copies of relevant extracts from Mr Kirsch's prison and medical records.

14. The investigator interviewed 14 members of staff and a prisoner at HMP Long Lartin between 21 and 23 May 2018, and one member of staff by telephone on 23 August 2018.

15. NHS England commissioned an independent clinical reviewer to review Mr Kirsch's clinical care at the prison. The clinical reviewer conducted 14 joint interviews with the investigator.

16. We informed HM Coroner for Worcestershire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Kirsch's father to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. Mr Kirsch's father did not raise any issues. However, the Coroner's office informed the investigator that the family was very concerned about a lengthy complaint process Mr Kirsch had instigated at Long Lartin about prison staff. The family wanted to know whether the complaints had been taken seriously and if they had any bearing on his death.

18. Mr Kirsch's family received a copy of the initial report. They did not make any accuracy comments.

19. The prison service also received a copy of the initial report. Their response to our recommendations and action plan is annexed to this report. They made minor accuracy comments. We have amended the report accordingly.

Background Information

HMP Long Lartin

20. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 621 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Care UK, with mental healthcare subcontracted to South Staffordshire and Shropshire NHS Foundation Trust Mental Health Team.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Long Lartin was conducted in January 2018. Inspectors reported that strategic management of suicide and self-harm prevention was good and ACCT case management for prisoners at risk of suicide and self-harm was implemented well. The quality of ACCT documentation was very good: care plans were completed and actioned, reviews were well attended and observational entries informative. Prisoners in crisis were generally positive about the care they received. The prison had made very good progress in meeting the Prisons and Probation Ombudsman's recommendations following investigations into three earlier self-inflicted deaths at Long Lartin.

22. Routine mental health referrals were reviewed weekly and prisoners accepted onto the caseload after assessment were assigned an appropriate caseworker. There was a duty worker for the team so urgent referrals could be seen rapidly within 48 hours, and frequently on the same day if significant risks were identified. Services were available five days a week. Waiting times were short and better than those found in equivalent community services. The team made effective contributions to relevant ACCT procedures and attended all initial ACCT assessments.

Independent Monitoring Board

23. In its latest annual report for Long Lartin, for the year to 31 January 2018, the Board highlighted that towards the end of the reporting year incidents of self-harm and prisoner-on-prisoner assaults had shown downward trends.

Previous deaths at HMP Long Lartin

24. Mr Kirsch was the seventh prisoner to die at Long Lartin since January 2015. Of the other six, three prisoners took his own life, two were murdered and one death is awaiting classification. Three prisoners have died since Mr Kirsch's death.

Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and

intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

26. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk from self, to others and from others (Safer Custody)*.

Incentives and Earned Privileges (IEP) Scheme

27. Each prison has an Incentives and Earned Privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of reoffending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels: entry, basic, standard and enhanced.

Key Events

28. On 23 May 2008, Mr David Kirsch was sentenced to life imprisonment for the murder of his partner, with a minimum tariff of 18 years and five months before he was eligible for parole. He was sent to HMP Winchester and then spent time at three other prisons before being transferred to Long Lartin in 2013.

29. At his initial health screening, a nurse recorded that Mr Kirsch did not have ongoing problems with drug abuse, although he had worked with the substance misuse team in other prisons and had successfully undertaken a detoxification programme. The nurse also recorded that Mr Kirsch did not have thoughts of suicide and self-harm. Mr Kirsch suffered from epilepsy, for which he was taking carbamazepine, a medicine to control epileptic seizures, but had not had a fit in the previous five months.

30. In February 2014, an officer submitted an intelligence report, made an entry on NOMIS (National Offender Management Information System) and issued a self-harm alert because she noted that Mr Kirsch had said during a post-sentence probation interview that he did not intend to serve all his sentence. He said that as soon as his father died he was going to kill himself. Mr Kirsch later said that he no longer wanted to die when his father died because he wished to live for his daughter.

31. Mr Kirsch had mental health reviews during the next eight months but was not diagnosed with a mental health problem. He had no further formal engagement with the mental health team until August 2017 and there were no further intelligence reports related to his suicide and self-harm risk until 2018.

2016

32. On 22 February and 12 March, a wing officer issued a negative behaviour entry and an IEP warning to Mr Kirsch as she said Mr Kirsch had been very aggressive towards her and she had felt intimidated by his attitude. Mr Kirsch felt that the negative entry and the warning were unfair and submitted a complaint. A supervising officer (SO) replied to the complaint on 16 March, saying that he considered that the officer's actions had been appropriate. Mr Kirsch's relationship with the officer started to deteriorate after this and he made a number of further complaints about her.

33. On 31 March 2016, a case worker recorded Mr Kirsch wanted to rebuild his relationship with his daughter. Although Mr Kirsch had not been in contact with his daughter since she was six years old, he hoped that she would contact him when she turned 18 on 5 April 2016 and became an adult. The case worker said that Mr Kirsch became emotional when speaking about his daughter but recorded that she did not consider that Mr Kirsch was at any or higher risk of suicide and self-harm. Mr Kirsch's daughter never contacted Mr Kirsch while he was in prison.

2017

34. On 28 February 2017, Mr Kirsch asked that some case notes made by an officer in his NOMIS record be removed because they were inaccurate. A prison

manager replied to Mr Kirsch on 14 March. He said that no amendments or deletions could be made to the records, but he suggested that Mr Kirsch ask his offender supervisor to consider whether any additions could be made.

35. On 23 August, a recovery worker from the substance and mental health team and a social worker assessed Mr Kirsch for substance misuse and mental health issues. Mr Kirsch said that he was not going to use any drugs, including psychoactive substances (PS). The recovery worker and social worker assessed that Mr Kirsch would benefit from monthly psychosocial therapy and supportive work on coping strategies, and they created a care plan.

36. On 8 December, Mr Kirsch's offender supervisor met Mr Kirsch to discuss his request to add corrective comments to his NOMIS record, as suggested by the manager on 14 March. Mr Kirsch wanted the additional comments to be critical of the officer. The offender supervisor did not agree with this. He said that Mr Kirsch's behaviour deteriorated then to the point of jabbing him with his finger. He asked Mr Kirsch to leave his office. Four days later, Mr Kirsch submitted a complaint about his offender supervisor saying that he had missed a number of appointments and had not acted professionally.

2018

37. On the morning of 20 January 2018 (Mr Kirsch's 52nd birthday), Mr Kirsch told a nurse that he "was not worthy of life" and that he had been asking another prisoner to kill him. Mr Kirsch also told the nurse that "he wanted to go" because he had done a terrible thing as he had killed someone. (This was in relation to his offence.)

38. Mr Kirsch told the nurse that he planned to kill himself by running into a wall or jumping off the bed to break his neck. The nurse immediately started ACCT procedures and wrote in the 'concern and keep safe form' that Mr Kirsch was "presenting erratic" and had spoken about his offence.

39. A prisoner, who was a friend of Mr Kirsch, told the investigator that on the morning of his birthday, Mr Kirsch came out of his cell in tears and said that he was worried that he was never going to see his daughter and father again and that he had a recent death in his family. Mr Kirsch said that he could not stand prison life any longer and wanted to kill himself. The prisoner also said that this was the first time that Mr Kirsch had ever mentioned anything like this to him so he was shocked.

40. At around 10.15am, Mr Kirsch jumped off his bed and hit his head several times. A nurse attended after staff radioed a code red emergency. (This indicates that a prisoner has severe loss of blood.) At around 12.20pm, staff took Mr Kirsch to the healthcare unit where nurses treated the cuts to his head. Later that day, farewell letters Mr Kirsch had written to his father and his friend were found in his cell.

41. A SO recorded in the ACCT action plan that Mr Kirsch was to remain on constant watch in the healthcare unit and that nurses would carry out neurological observations every two hours.

42. On 21 January, during a morning neurological observation, Mr Kirsch jumped off his bed and hit his head on the sink, causing further cuts. Nurses glued the cuts in the treatment unit. A SO recorded that while Mr Kirsch was being escorted back to his room after this, he ran away from the staff "at full speed" and hit his head against a metal gate into the healthcare unit. Nurses sent Mr Kirsch to hospital where he was treated for his injuries. At around 7.30pm, Mr Kirsch returned to Long Lartin and was again placed under constant watch in the healthcare department.

43. At around 9.30pm, a nurse transferred Mr Kirsch back to hospital due to concerns about a swelling under his left eye, his breathing, headaches and pain in his chest., Mr Kirsch remained in hospital for 15 days. A SO assessed that Mr Kirsch's risk of suicide and self-harm was high and that he should continue under constant watch on his return to prison, but staff did not outline any specific support plan in the ACCT document for his return

44. On 5 February, Mr Kirsch returned from hospital and was located in the healthcare unit. The same day, a custodial manager (CM), a prison manager, a SO and a nurse carried out an ACCT case review. Mr Kirsch told staff that he had had time to reflect and said he realised that he had made a mistake in trying to kill himself. He said that he wanted to see his daughter, that his life had value and that he was not going to self-harm again. Staff recorded that Mr Kirsch was positive about the future and assessed that his level of risk was 'raised'.

45. A CM recorded that staff planned to work with Mr Kirsch so that he could go back to A Wing, but they did not update the caremap with any specific actions to support him or build any resilience. At this point the ACCT caremap included an action to maintain and document Mr Kirsch's behaviour while in hospital and an action to healthcare staff to review his family issues when he returned from hospital. (The caremap was not updated any further until a review in March.) The review on 5 February, decided that staff should carry out four observations per hour during the day and night.

46. On 6 February, a SO, the recovery worker and the chaplain carried out another ACCT case review. Mr Kirsch said that he hoped that his daughter was going to contact him as she was an adult. He expressed remorse that he had not been able to support her. When the SO asked him if he had contacted her, he replied that "he had very strict morals and that he had lost that right". He also said that "he had taken away her father from her and that she had missed out from his love and protection". Mr Kirsch spoke about his father and became sad because his father was suffering from heart problems. He expressed regret for the stress he may have caused with his attempt to kill himself.

47. Mr Kirsch asked for his ACCT observations to be decreased because he had difficulty sleeping due to the level of staff observations, but the SO decided the observations should remain the same. Staff assessed Mr Kirsch's level of risk for suicide and self-harm to be high. Although this assessment was an escalation of risk from the previous case review, no specific actions were taken to address it and the caremap was not updated.

48. On 7 February, Mr Kirsch had another ACCT case review attended by a SO and the recovery worker. He did not raise any major concerns. Staff reduced his risk

to ‘raised’ and reduced the level of observations to twice every hour. The caremap was not updated with any actions. The next day, a SO and the chaplain carried out another case review. The SO recorded that Mr Kirsch presented well and repeated that he would never put again his family through the stress he had in January. The SO assessed Mr Kirsch level of risk as still ‘raised’ and reduced the level of staff observations to one observation per hour supported by a conversation in the morning, afternoon and evening. The caremap was not updated.

49. On 9 February, a Multidisciplinary Team Meeting attended by the recovery worker and other members of the substance misuse and mental health team, discussed how depressed Mr Kirsch was reported to be by the lack of contact with his daughter. Although he had told the recovery worker that he felt better and was focusing on the future, she was worried that Mr Kirsch’s situation and issues had in fact not changed and that his mood could deteriorate rapidly as it had done in January. She arranged for a psychiatric review to be carried out.

50. On 13 February, a psychiatrist assessed that Mr Kirsch did not show any signs of thought disorder or delusional content and concluded that there was no evidence of affective or psychotic illness. He said that Mr Kirsch should continue to be managed through the ACCT process with the support of his recovery worker. He concluded that there was no need for further psychiatric input.

51. Following the psychiatrist’s review, the recovery worker spoke to the safer custody department and submitted an intelligence report highlighting trigger dates of self-harm and suicide for Mr Kirsch so that staff were aware of these. They included his birthday on 20 January and his daughter’s birthday on 5 April. Staff recorded that Mr Kirsch’s daughter was now an adult and that Mr Kirsch hoped she would be in contact.

52. The same day, Mr Kirsch returned to A Wing. During an ACCT case review he told a SO that he was feeling better physically and told another SO that he was happy to go back to the wing. They assessed Mr Kirsch’s level of risk as “low” and reduced the level of observations and conversations to one conversation in the morning, one in the afternoon and one in the evening, and then observations of once an hour at night, because Mr Kirsch said that he did not have any thoughts of self-harm. The caremap was not updated.

53. On 15 February, Mr Kirsch told a SO and a worker from the substance and mental health team, during another ACCT review, that he was seeing the future a lot brighter and that it scared him to think about the damage he caused to himself when he self-harmed in January. The SO recorded that Mr Kirsch presented as a more positive individual and assessed that his level of risk of suicide and self-harm continued to be low. The SO reduced the level of staff observations to one conversation in the morning, one during the afternoon and one during the evening and three observations during the night. The level of observations remained unchanged until Mr Kirsch died.

54. On 20 February, a SO chaired a multidisciplinary case review also attended by a chaplain and the recovery worker. The SO recorded that Mr Kirsch appeared to be in good spirits and was open about why and how he had self-harmed. The SO said that Mr Kirsch was working closely with his recovery worker and the

mental health services. She said that she had developed a crisis plan with Mr Kirsch to address any sudden changes in his mood. She told the investigator that she spoke to the officers about Mr Kirsch's existing support networks, which included a friend in A Wing and his father. The SO assessed that Mr Kirsch's level of risk had not changed (it continued to be low) but that he felt that it was too early to reduce the level of staff observations and conversations any further.

55. On 27 February, a SO reviewed Mr Kirsch with the recovery worker and a chaplain. The SO recorded that Mr Kirsch appeared to have settled well back in A Wing and was happy to be back at work. He was also expecting a visit from his sister and father. The SO assessed that Mr Kirsch's risk of suicide and self-harm continued to be low and he did not change the level of staff observations and conversations. The next day, Mr Kirsch had a one-to-one session with his recovery worker. She said that Mr Kirsch was positive and was benefiting from his support networks.

56. On 2 March 2018, Mr Kirsch told a SO during an ACCT case review that he did not have any current thoughts of suicide and self-harm and wanted his ACCT monitoring to conclude, although he wanted to continue meeting with his support worker. The SO recorded that Mr Kirsch had apologised to his father and sister for his actions in January and that he had written to healthcare staff, the Governor and hospital staff thanking them for their support. The SO decided to keep Mr Kirsch's ACCT open with a view to closing it if his recovery worker could confirm that she was going to continue reviewing Mr Kirsch during the next month.

57. On 7 March, the recovery worker reviewed Mr Kirsch. During this session they created a support network map. Mr Kirsch identified as key support for him, a prisoner who was his neighbour and an old friend who he trusted, also his father and sister, his great aunt and the staff on A Wing who Mr Kirsch said listened to him and had helped him in time of need.

58. On 9 March, Mr Kirsch told a SO and a mental health nurse at an ACCT case review that he had an ongoing confidential matter that was keeping him awake at night. He said he did not want to discuss it due to the nature of the matter. He said that a complaint he made was bothering him. Mr Kirsch commented that he was going to have a visit from his father and sister and that he expected it to be emotional.

59. The SO said that Mr Kirsch would not provide more detail of the matter that was bothering him and assessed that Mr Kirsch remained at low risk of suicide and self-harm. They decided to continue monitoring him through the ACCT procedures, with the same level of observations. The nurse recorded that they agreed to keep the ACCT open for another week because Mr Kirsch "still had issues on his mind" and to see how the visit went.

60. On 13 March, at 2.06pm, Mr Kirsch had a fight with another prisoner in A Wing. Mr Kirsch's friend, who witnessed the incident, told the investigator that the fight started because another prisoner was making false comments about him and Mr Kirsch "wanted to support" him. Mr Kirsch punched and bit the other prisoner's face and they continued fighting on the floor for two minutes. Mr Kirsch's friend

said that Mr Kirsch realised shortly after the event that he had overreacted, and regretted his behaviour.

61. An officer recorded that CCTV footage showed the other prisoner having a conversation with Mr Kirsch and his friend. A fight started between Mr Kirsch and the other prisoner and they fell on the floor and rolled around. The fight lasted for approximately two minutes. He recorded that they then stood up and briefly entered Mr Kirsch's cell before the other prisoner went to the recess to wash the blood on his face.

62. A SO and CM started a violence reduction investigation and submitted an intelligence report. During the investigation, the other prisoner told officers that nothing had happened. Mr Kirsch, who the CM described as being very tearful following the incident, said that he was trying to protect himself.

63. On 14 March, the SO and CM reduced Mr Kirsch and the other prisoner to the basic level of the IEP scheme. Mr Kirsch was placed on a disciplinary charge. The SO and CM told the investigator that somebody from the security department (they did not remember the name) decided to relocate Mr Kirsch to B Wing on this date. After Mr Kirsch's move, a SO recorded during an ACCT case review that Mr Kirsch appeared to be in good spirits and said that he understood why he had been moved. The SO assessed Mr Kirsch's level of risk as low and continued with the same observations.

64. On 15 March, a prison GP reviewed Mr Kirsch. He told her that he had been low in mood for a long time and discussed his previous attempts to kill himself. The GP identified that Mr Kirsch had increased stress as he was going to have an adjudication hearing and his family was going to visit him later. She considered that although there was no evidence that Mr Kirsch had a thought disorder, he was showing signs of anxiety and depression and would therefore benefit from medication. The GP prescribed Mr Kirsch with 20mg of citalopram, an antidepressant, to be dispensed every morning at the wing's medication counter and not to be kept in possession. This was the first time that Mr Kirsch had been prescribed medication for his mental health.

65. The same day, Mr Kirsch pleaded guilty at his adjudication hearing and the matter was adjourned for referral to the police. Mr Kirsch then had a visit from his father and sister. His father had not visited him since November 2017 and his sister since June 2015.

66. On 16 March, Mr Kirsch told a SO during an ACCT case review, that he felt that he had settled well on B Wing where he knew some prisoners and found staff approachable and helpful. The recovery worker could not attend the review because she was on annual leave but she had spoken to the SO the day before. She was aware of Mr Kirsch's recent fight, and adjudication hearing and that his family was going to visit him and suggested that Mr Kirsch remain under the ACCT process. She also said that she was going to review Mr Kirsch the following week (Mr Kirsch killed himself before this could happen). The SO told the investigator that the case review focussed on Mr Kirsch's move to B Wing but that no discussion took place around Mr Kirsch's fight, adjudication and family visit or their implications for his risk. The SO decided to continue the ACCT with the same level of observations.

67. On 17 March, Mr Kirsch spoke to a nurse following a medication round on the wing. Mr Kirsch said that he was anxious because he had pleaded guilty at his adjudication hearing but did not have time to explain the circumstances of the fight. He was worried that he was going to get extra-time in his sentence without his side of the story having been considered. The nurse said that Mr Kirsch was "quite emotional" and that she thought that his ACCT observations should be increased. She mentioned this to the SO. The SO spoke to Mr Kirsch and told him that he could appeal against the outcome. Mr Kirsch accepted the explanations and calmed down. On this basis, the SO assessed that his level of risk and observations did not need to be increased.

19 March 2018

68. On 19 March, at around 4.30pm, Mr Kirsch's friend and another prisoner saw Mr Kirsch returning from his workshop and went to greet him. Mr Kirsch's friend told the investigator that he became very concerned about Mr Kirsch's presentation because his handshake "was empty with no grip and no sincerity". He said he sensed that Mr Kirsch was going to kill himself so he went to speak to the SO and asked him to speak to somebody on B Wing. The SO told the investigator that Mr Kirsch's friend did not specifically tell him that he felt Mr Kirsch was going to kill himself but that he and another prisoner were concerned because Mr Kirsch "did not look right". The SO spoke to a SO on B Wing and asked him to meet Mr Kirsch and ensure that he was fine.

69. At around 5.20pm, a SO on B Wing spoke to Mr Kirsch. He told the investigator that a SO on A Wing told him that two prisoners were concerned about Mr Kirsch because he "was looking down and was depressed" and asked him to "have a word with him". The SO said he had asked staff whether they had any concerns about Mr Kirsch but nobody raised any. He also said that Mr Kirsch appeared to be fine but mentioned to him that "he had bitten somebody" during a fight, something he had not done before. Mr Kirsch said that he thought at the time that it was the right thing to do. The SO said that Mr Kirsch then asked him what he recommended and the SO suggested he contact the mental health team as they could help him with any concerns about his behaviour. He sent an email to the mental health team asking them to review Mr Kirsch.

70. The SO told the investigator that he did not think that Mr Kirsch was at any risk of suicide and self-harm at that point because he presented well, so he did not think he needed to increase the frequency of ACCT observations. He made a record of the conversation in the ACCT document.

71. At 5.59pm, CCTV shows that Mr Kirsch entered his cell then left and then returned a minute later. At 6.31pm, an officer arrived at Mr Kirsch's cell to ensure that his cell was locked. She looked through the observation panel twice and at 6.33pm left the landing. She said that when she opened the flap she saw Mr Kirsch standing near his table. She told the investigator that she did not note anything concerning and that she said "night" to Mr Kirsch who also responded "night".

72. At around 7.50pm, an officer started to do a roll check on B Wing and looked through Mr Kirsch's observation panel. The cell light was on and he saw Mr Kirsch lying on the bed with his eyes closed. The officer said that he could see a

"stain" on the front of Mr Kirsch's tee-shirt which he initially thought was sweat but then he saw blood on Mr Kirsch's arm which was hanging down. The officer immediately called an emergency code red over the radio which the control room officer recorded as having been radioed at 7.52pm. The officer then returned to the landing office. The control room officer called an ambulance a minute later. The officer said that as soon as he saw Mr Kirsch he realised that his life was in danger but that he did not enter the cell or ask the control room for authorisation to enter the cell because "it is a policy at Long Lartin that you never, ever, enter a cell on your own".

73. At around 7.53pm, four officers, a CM and a SO arrived at the landing. The CM gave authorisation for the cell door to be opened, as the prison was in patrol state, the style of wing is one that is electronically locked. Two nurses arrived. The CM opened the cell and entered with an officer.

74. The officer said that he saw that Mr Kirsch had blood down his front and there was blood on the floor but he could not see any blood flowing. Mr Kirsch had cut his neck with a tin can lid. The officer said that the blood on the floor covered a four-foot area and that there was a bucket with approximately an inch of blood in the bottom of it. He said that he could see congealed blood around Mr Kirsch's neck. He checked for Mr Kirsch's pulse but found none. The officer said that Mr Kirsch was pale and was not breathing. A nurse also checked Mr Kirsch and noted that he had no pulse, was grey in colour and was cold to touch. The nurses assessed that Mr Kirsch had died and did not attempt to carry out cardio-pulmonary resuscitation (CPR) because signs of death were already present and he had lost a large amount of blood.

75. At 8.10pm, as recorded in the control room log, the ambulance arrived at the prison. Audio recordings of the contact between the prison and the ambulance service show that the ambulance service manager asked the control room officer if Mr Kirsch was dead. The control room officer confirmed that healthcare staff had not started CPR because they believed Mr Kirsch was dead. The ambulance crew said that their function was to preserve life not to certify death so decided not to enter to the prison and attend Mr Kirsch's cell.

76. At 10.33pm, an out of hours GP, called by the nurses, pronounced Mr Kirsch dead.

Contact with Mr Kirsch's family

77. At around 11.00pm, a prison chaplain went to Mr Kirsch's father home to break the news of his son's death but, as he was living in sheltered accommodation, and given the late hour, they decided not to tell him that night.

78. The next day, the chaplain asked a family liaison officer (FLO) at HMP Belmarsh to help in breaking the news to Mr Kirsch's father. At around 9.35am, the FLO went to Mr Kirsch's father's home with an officer. They spoke to the housing manager, broke the news and offered support. The FLO at Long Lartin continued contact with Mr Kirsch's family thereafter.

79. Mr Kirsch's funeral was held on 27 April 2018. The prison offered to contribute to the costs in line with national guidance.

Support for prisoners and staff

80. After Mr Kirsch’s death, a CM debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

81. The prison posted notices informing other prisoners of Mr Kirsch’s death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Kirsch’s death.

Post-mortem report

82. A post-mortem examination established the cause of death as haemorrhage and incised wound to right side of Mr Kirsch’s neck. Toxicology tests revealed no illicit drugs or medication. An addendum toxicology report concluded that PS screening revealed no significant finding.

Findings

Assessment and Management of risk

83. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, provides a non-exhaustive list of a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. These require staff to take appropriate action, including starting ACCT procedures, if necessary.

84. Mr Kirsch presented with the following risk factors for suicide and self-harm at Long Lartin:

    - the nature of his offence and the victim being his partner (Mr Kirsch repeatedly expressed remorse for his actions);
    - poor family relationships, specifically the lack of contact with his daughter;
    - a history of anxiety and depression and involvement with mental health services;
    - statements of suicidal intent, such as his statement at a pre-sentence planning report that he did not intend to serve all his sentence and that he was going to kill himself as soon as his father died; and
    - suicide attempts and acts of self-harm on 20 and 21 January.

85. A week before Mr Kirsch killed himself, a number of unsettling events took place which we consider may have increased his vulnerability and risk of suicide and self-harm:

    - a fight on 13 March which was unprecedented for Mr Kirsch for which he felt remorse and was very emotional about afterwards;
    - his move from A Wing to B Wing the next day (which separated him from his friend who had been identified as a key support);
    - the adjudication hearing on 15 March which he felt might see his sentence extended and where he did not feel his side of the argument had been heard; and
    - his father's visit on 15 March which was the first since November 2017, and his sister's, which was the first since June 2015. His father was very important to him and a prison GP had identified that Mr Kirsch was stressed prior to this visit.

86. Although staff started ACCT monitoring for Mr Kirsch after the events on 20 and 21 January and the recovery worker worked very diligently and effectively to support Mr Kirsch and identify his protective factors, we found the following deficiencies in his overall management.

Assessment

87. We consider that following Mr Kirsch's attempts to kill himself on 20 and 21 January, his level of risk remained significant, but was poorly understood and hence unaddressed. The ACCT guidance sets out that indicators of raised risk could be previous, especially recent, suicide attempts, evidence of depression and a current unsettling situation or emotional pain. These were all present. The recovery worker told the investigator that Mr Kirsch continued to be at risk of a

dramatic changes in his behaviour, as happened on 20 and 21 January when he tried to kill himself.

88. On 13 February 2018, two SOs assessed that Mr Kirsch's level of risk had reduced to 'low' because he was happy to go back to A Wing, felt better and did not have any thoughts of self-harm. We do not consider that these were sufficient reasons to reduce the assessed level of risk given the underlying and unaddressed risks with which he presented.

89. Staff continued to assess Mr Kirsch as a low risk until he died based on his presentation and his reassurances that he was well and was not going to kill himself. During the days leading up to his death, we consider that ACCT reviews missed opportunities to understand and address Mr Kirsch's level of risk, specifically considering his move from A to B Wing, the adjudication and the visit from his father and sister, which were all potentially emotionally unsettling events.

90. It is notable that the recovery worker had identified all of these and the impact of the fight as relevant to Mr Kirsch's risk. It is unfortunate that she was unable to attend the final ACCT review. However, she had spoken to the SO who chaired the review, and the review should have considered these factors.

91. On 19 March, hours before Mr Kirsch killed himself, a SO spoke to Mr Kirsch on B Wing after concerns were raised by his friend and another prisoner. The SO said that a SO on A Wing had passed him the message from the prisoners, that "Mr Kirsch was "looking down and was depressed" and asked him to speak to him. The SO on B Wing who knew very little about Mr Kirsch, did not check his ACCT document and was therefore largely unaware of previous evidence of Mr Kirsch's risk of suicide and self-harm and his recent triggers. He assessed that Mr Kirsch presented with no risk factors for suicide and self-harm.

92. He told the investigator that Mr Kirsch caused him no concern and that he thought that it was not necessary in the circumstances to review or increase Mr Kirsch's level of risk and observations. He accepted that somebody who had a good knowledge of Mr Kirsch (like some staff members working on A Wing) might have thought differently.

93. In April 2014, we published a Learning Lessons Bulletin on 'Risk Factors in Self-Inflicted Deaths in Prison'. We identified that staff often place too much weight on how a prisoner presents, rather than on existing risk factors. The bulletin highlighted that prisoners will often withhold the extent of their distress from staff, and evidence of risk should be fully balanced against how the prisoner presents. We believe that staff wrongly over-relied on Mr Kirsch's presentation to assess his risk, decide on the frequency of staff observations and the support he required.

Caremaps

94. PSI 64/2011 requires caremaps to be completed during the first ACCT case reviews and that they reflect the prisoner's needs, level of risk and their triggers of distress. They should aim to address issues identified in the ACCT assessment interview. They must be tailored to meet prisoners' individual needs

and reduce risk. They must be time-bound and state who is responsible for completing the action. They should also be updated following every case review.

95. Mr Kirsch had 17 case reviews during the time he was subject to ACCT management but the caremap was only updated on five occasions. Staff set out actions such as “staff to maintain and document behaviour while in hospital”, “family issues to be reviewed when he returns from hospital”, “to settle in to life on B Wing” or ‘to speak to a mental health key worker’. We consider that some of these actions were generic, some were not sufficiently tailored to Mr Kirsch’s specific needs and some were not effectively discharged.

96. The ACCT guidance provides a non-exhaustive list of caremap considerations which include peer support, wing moves, wing activities and family contact. All were relevant in Mr Kirsch’s case but unfortunately they were not properly considered. We are particularly concerned that no consideration was given to addressing his underlying anxieties. For example, the caremap did not contain any specific actions that might have helped to address Mr Kirsch’s concerns about the fight, the adjudication, or his relationships with his family members, and no consideration was given to the possibility of involving his family in case reviews.

Sharing information

97. In our Learning Lessons Bulletin on prisoner mental health, published in January 2016, we said that it is vital that relevant information is communicated to prison staff when mental health problems are identified by healthcare staff. This will allow them to be as informed as they can be about a prisoner’s need and can play a part in providing support. When prison staff are well informed about a prisoner’s mental health issues, this can help them to relate to that prisoner’s behaviour, to recognise distress and to respond in the most appropriate manner to support that prisoner.

98. On 15 March, a prison GP reviewed Mr Kirsch and identified that he was under increased stress as he was going to attend an adjudication and was going to have a family visit. Mr Kirsch told the GP that his mood had been low for a long time. The GP assessed that Mr Kirsch was showing signs of anxiety and depression. She told the investigator that she discussed with him how anxiety and depression had affected him day to day in dealing with emotions and stresses and the negative impact those symptoms had on helping him deal with his daily issues.

99. The GP was sufficiently concerned that she prescribed an antidepressant. However, the GP did not communicate her concerns about Mr Kirsch’s mood and stress factors to his recovery worker or to wing staff, nor that she had prescribed him with antidepressant medication.

100. We consider that this information should have been shared as it would have helped staff at the last ACCT case review on 16 March to make a more informed judgement about Mr Kirsch’s level of risk of suicide and self-harm and explore in depth the issues that were causing him stress or emotional pain.

Wing move and support networks

101. On 7 March, Mr Kirsch's recovery worker discussed his support networks with him and created a map. It included A Wing officers who knew him, interacted well with him and were aware of his history. It also included a prisoner, who was a very close friend with whom Mr Kirsch spoke frequently. The recovery worker said that his friend was important as he was someone in whom he could "confide and get things off his chest" at any time. The recovery worker had communicated the importance of this networks to officers during ACCT reviews.

102. The fight on 13 March was unprecedented for Mr Kirsch who was not known to be associated with gang-related or other violent behaviour. He expressed a great deal of remorse after the events. The investigator asked the officers the rationale for their decision to move Mr Kirsch as it was clear that keeping Mr Kirsch on A Wing where he had a support network would have been beneficial to him.

103. The SO said that Mr Kirsch and the other prisoner each had a 50/50 chance of being moved. The CM said that when making the decision to move Mr Kirsch, it was not clear who was the perpetrator or the victim of the fight. Although he said that staff had taken Mr Kirsch's welfare into account when making the decision, he was vague in his explanation.

104. We recognise that it is difficult for staff to strike the right balance between maintaining order and control and ensuring that the welfare of prisoners is appropriately safeguarded. However, given Mr Kirsch's level of risk and history and the fact that he was on an ACCT, we are not satisfied that staff gave sufficient consideration to the impact a move might have on Mr Kirsch's welfare. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that they:

- **identify risk factors and assess a prisoner's risk considering his history and not just his personal presentation;**
- **complete and update caremaps at case reviews setting out specific and meaningful actions, including involving the family where appropriate, identifying who is responsible for actions and reviewing progress at each review;**
- **share information to provide collaborative care and treatment, in particular ensuring effective communication between healthcare and prison staff when there are concerns about a prisoner's mental health; and**
- **take into account the potential impact of restrictive measures addressing violence reduction and disciplinary issues on the welfare of prisoners with a clear history of suicide and self-harm.**

Clinical Care

105. The clinical reviewer considered that the overall healthcare provided to Mr Kirsch was in line with good practice and that there were no delays in access to care. Each member of healthcare staff dealt with the issues presented appropriately, although in the last few days before Mr Kirsch's death there were failures in communication and in providing a holistic approach to risk assessment. The clinical reviewer therefore concluded that Mr Kirsch's healthcare was equivalent to that which he could have expected to receive in the community.

Entering Mr Kirsch's cell

106. Prison Service Instruction (PSI) 24/2011, which covers management and security at night, states that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over the usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, individual member of staff can enter the cell on their own. Staff are not expected to take action where they feel it would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

107. HMP Long Lartin's night instructions state that if in the opinion of the discovering member of staff there is an urgent situation where the prisoner is in immediate serious danger, cells can be unlocked without the authority of the Night Orderly Officer and a staff member may enter a cell on his own.

108. At night on 19 March, an officer recognised that Mr Kirsch's life was in danger when he discovered him on his bed covered in blood. He correctly radioed a code red emergency but did not consider entering the cell on his own because his understanding was that he should never do so. Other staff rapidly attended, and it is unlikely that earlier intervention would have affected the outcome for Mr Kirsch. However, in other circumstances entering a cell immediately could be critical. We are concerned that staff at Long Lartin did not appear to understand or comply with national and local instructions. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of PSI 24/2011 and the prison's night instructions and that they understand that, subject to a personal risk assessment, they should consider entering a cell at night when there is a risk to life or immediate serious danger.

Emergency Response

109. Nurses told the investigator that Mr Kirsch was grey in appearance, cold to touch and that there were no signs of life when they examined him. The nurses concluded that he was in haemorrhagic shock due to his extensive blood loss. They also noted the presence of blood pooling in Mr Kirsch's hands. The clinical reviewer concluded that the nurses' decision not to start CPR was in line with current national guidance.

Mr Kirsch's complaints

110. PSI 02/2012, *Prisoner Complaints,* sets out a two-stage internal complaints process for prisoners' complaints. Complaints are submitted on a Comp1 form. There is also a confidential access system for prisoners to submit complaints about staff direct to the Governor on a Comp2 form. The PSI says that responses to complaints must address the issues raised in the complaints and that prisoners must receive an understandable written response normally within five working days of the complaint being logged or ten working days if the complaint is against a member of staff. If a prisoner is dissatisfied with the response to a complaint, he can appeal using a Comp 1A form. (If a prisoner remains dissatisfied after completing the two internal complaint stages, he can complain to the PPO.)

111. The prison provided the investigator with the record of 13 complaints submitted by Mr Kirsch between March 2016 and December 2017. We have summarised these in the annexed 'chronology of complaints' document. Mr Kirsch's family was concerned that staff did not take these complaints seriously and that this may have had an impact on Mr Kirsch's welfare. Mr Kirsch complaints were about specific incidents with an officer, about staff decisions on his IEP level and about the disclosure of documentation.

112. A key outcome that Mr Kirsch's pursued through the complaints system was to remove some entries made in NOMIS by an officer which he perceived to be inaccurate. A manager responded to Mr Kirsch's initial complaint about this issue within ten working days. He said that although it was not possible to remove the entries, it was possible to add additional information to the records if it was deemed appropriate, and he asked his offender supervisor to deal with the matter.

113. The offender supervisor told the investigator that he met Mr Kirsch in March 2017 and that in May he drafted the information to be added but Mr Kirsch was not happy with his proposal. He said that he nevertheless added the information containing Mr Kirsch's version of events in two NOMIS entries made on 22 February 2016 and 12 March 2016. Mr Kirsch then wanted to discuss the issue again and met him on 8 December but the meeting was not successful.

114. Mr Kirsch then submitted a complaint about his offender supervisor, saying that he had acted unprofessionally. A CM responded on 18 December 2017, three working days later. The CM contacted the offender supervisor and invited Mr Kirsch to work with him to resolve the issue. The offender supervisor continued engaging with Mr Kirsch but told the investigator that no other formal meetings took place. He said that he met Mr Kirsch in February 2018 and that Mr Kirsch told him that he was not going to pursue the matter any further but requested a copy of the comments added by him, which he sent to Mr Kirsch on 5 March 2018.

115. Mr Kirsch's friend, who helped Mr Kirsch write some of the complaints, said that the process was very stressful for Mr Kirsch who eventually became 'fixated' with the matter. He said that when the situation did not go the way Mr Kirsch hoped it was going to go, "he became out of control". He said, though, that he did not believe that this had a direct bearing on Mr Kirsch's decision to kill himself,

because he had other more significant concerns, particularly his remorse about his offence and the lack of contact with his daughter.

116. We found that staff responded to Mr Kirsch’s complaints in a timely fashion, and provided clear, courteous responses which took his concerns seriously in line with PSI 02/2012.

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